One RN's Experience Reducing Unit Conflict and the Use of Restraint and Seclusion

For the first 10 years of my nursing career, I worked primarily on an 11-bed psychiatric intensive care unit in Winnipeg, Canada. This unit is intended to serve adults experiencing acute symptoms of a serious mental illness (e.g., schizophrenia, bipolar disorder). Historically, the average length of stay was approximately 3 weeks, as the unit was designed to offer treatment to individuals at the highest risk for aggression, although longer stays have become more commonplace.

Our unit was chosen for a study to assess the impact of a restraint and seclusion (R/S) reduction initiative on several outcomes, including staff injury, seclusion episodes and duration, and the use of as-needed medications. Discussion and disagreement occurred among staff regarding this initiative and its implications. It became clear that what had been considered an often uncomfortable but seemingly necessary aspect of our job was implemented for different reasons among staff and was not rooted in evidence, as it ought to be.

Changing the way we prevented aggression and addressed escalating situations on the unit involved dispelling the notions that hospitalized individuals required consequences for their behavior and staff needed to show no tolerance for violence. We realized that our roles do not ask us to sit in judgment of the actions of individuals who are acutely ill. We also learned that we do not have to have the last word in every situation. Disagreement arose regarding what constituted *imminent danger*, which may still, at times, lead to the use of seclusion or, rarely, the use of restraints.

Immediately after receiving training in the Six Core Strategies© (Huckshorn, 2004), which preceded our hospital's initiative, our facility successfully completed 60 consecutive days without using R/S without any staff injuries. The number of episodes of seclusion and the duration of these episodes decreased significantly, as did staff injury rates, over the following year.

Making changes based on the Six Core Strategies allowed us to work with pride. For me, envisioning patients we care for as someone's best friend or family member and not a stranger is key. Individuals pay close attention to the kind of care they are given, and all nurses and other team members can have a significant impact on patients' recovery experiences.

Nurses have the potential to improve their role as health care providers. I recall some of the staff saying they wished that this initiative had occurred years earlier, as it could have changed the tone of their careers. It takes a great deal of personal investment to truly embark on this type of challenge, but it boils down to what kind of work you would rather be doing. Changing my own practice required me to consider whether I preferred to continue addressing crisis after crisis in an antiquated manner and experience the heartache and risk that it can entail, or commit to making myself more available to the individuals we serve by talking, listening, engaging in activities, and truly using all of my skills.

As more facilities consider R/S prevention or reduction initiatives, the following list of strategies, which represent simple, inexpensive, and easily applied interpretations of the Six Core

Strategies, proved to be effective on our unit:

- Visit individuals who are going to be admitted to the unit from the emergency department prior to the transfer. This opportunity helps build rapport with patients and can greatly reduce their anxiety, as the admission experience can be clarified.
- Create a *relaxation retreat*, which is a comfort room designed as a place to unwind using all of one's senses. It is an effective alternative in an escalating situation.
- Formulate safety plans that address potential triggers for aggression proactively and in collaboration with the individual affected.
- Debrief after an incident. Debriefing is essential, particularly at times when seclusion is used. In our unit, we ensured that if seclusion occurred, we had to learn from it, and the only way to really learn from it was to include the individual affected by the incident.
- Be flexible. When a challenge presents itself on the unit, ask whether it should be resolved with a new rule. Consider the gray areas. We resolved problems in individualized ways. We honed our assessment skills and got creative. We re-evaluated the written and unwritten rules on the unit, eliminating those without value and those that often led to unnecessary friction. Working without some of these hard-and-fast rules may be daunting, as the rules can be what we lean on when we are inexperienced or in a difficult situation. However, working without so many of them was liberating and empowering.

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Individuals who have been admitted to our unit since this initiative began have told us they notice the differences, which include a non-punitive atmosphere and more holistic care. They may not have been able to choose their circumstance of being admitted to the hospital, but they should receive the best possible recovery experience.

My hope is that initiatives to prevent R/S continue to help change our tired and outdated systems. We will all be better equipped when we decide to take a step back, not act so quickly, and proceed with genuine care.

REFERENCE

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The author has disclosed no potential conflicts of interest, financial or otherwise.

Posted: November 5, 2014

doi:10.3928/02793695-20141021-01